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The Role of Chaplains in Maintaining the Psychological Health of Military Personnel: An Historical and Contemporary Perspective

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ABSTRACT For many hundred of years, military forces have included chaplains of various faiths. Although these personnel mainly concentrate on providing for the religious and spiritual needs of the armed forces, they also contribute to the mental health of service personnel. This article provides a historical overview of military chaplains, examines their contributions to the psychological health of allied forces in World War I and World War II, and offers an overview of the scope of their present and future mental health related activities. The importance of the relationship between medical officers and chaplains in diagnosing and treating mental health problems is also discussed. We conclude that chaplains are capable of contributing significantly to the mental health of armed forces personnel if they are able to do so in informal and collaborative way.

INTRODUCTION

A soldier who is now known as Saint Martin of Tours was returning home from a journey when he met a cold and starving beggar. Saint Martin cut his cloak in two and gave one half to the beggar. Legend has it that the beggar was Jesus in disguise and many wonderful things followed. Saint Martin's cape became a sacred relic, a sign of the Lord's approval of all things military.¹

During the Middle Ages, Saint Martin's cloak, once one of the Frankish kings' most treasured possessions, was carried everywhere the king went; the soldiers who guarded the cloak were called Cappellani and this became the name for all priests who served in the military. The French translation of this word is chapelains, from which the English word chaplain is derived. The cape eventually became what is now known as the Colours and Standards, which symbolize today's armed forces.

Biblical records show that the Israelites took their religious advisors into battle with them; the same was true for the Romans.² During the medieval period, when the modern distinction between church and state did not apply, senior clergy-

men often led troops in battle. Thus the link between military forces and chaplains is a longstanding one, which predates the formation of the British Army in 1707. The aim of this article is to describe the historical and contemporary roles of chaplains within western forces in order to draw relevant conclusions about how they influence the mental health of service personnel and how they may continue to do so in the future.

WORLD WAR I

With a few high-profile exceptions, the diaries and memoirs of soldiers suggested that Anglican chaplains did not receive a good press. For example, George Coppard, a machine gunner, recalled that religion "meant compulsory church parades on Sundays if the company happened to be well out of the fighting zone. I had a glimpse of an army chaplain now and then, but never anywhere near the trenches."³ Indeed, on one occasion when a chaplain appeared in the trenches, his presence there was challenged by a sergeant. Frank Richards, a regular soldier in the infantry, observed that chaplains rarely visited the front line and some never left rear areas where they conducted church parades; few, apparently, gained the respect of front-line soldiers.⁴ In many cases, the memoirs of officers were no less critical. Robert Graves wrote,

For Anglican regimental chaplains we had little respect. If they had shown one-tenth the courage, endurance

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and other human qualities that the regimental doctors showed, we agreed the British Expeditionary Force might well have started a religious revival. But they had not, being under orders to avoid getting mixed up with the fighting . . . Soldiers could hardly respect a chaplain who obeyed these orders, and yet not one in fifty seemed sorry to obey them.⁵

One colonel, having dismissed a series of Anglican chaplains, arranged for a Roman Catholic replacement as they were “permitted to visit posts of danger . . . so that they could give extreme unction to the dying.”⁵ Siegfried Sassoon, a fellow officer in the Royal Welch Fusiliers, scarcely mentioned chaplains in his graphic account of trench warfare. Evacuated to an advanced dressing station, he recalled “listening to an emotional padre who was painfully aware that he could do nothing except stand about and feel sympathetic.”⁶ In their defense, British chaplains received no military training and recruited largely from the middle and upper classes had to work hard to establish a rapport with working-class soldiers. However, not all chaplains were so helpless as some assisted medical officers, dressing wounds and even administering anesthesia.

How valid is this largely literary view of the chaplain during World War I? A number of Anglican chaplains not only exposed themselves to danger but were decorated, Theodore Bayley, Noel Miles, and WRF Addison all being awarded the Victoria Cross.⁷ GA Studdert-Kennedy, nicknamed ‘Woodbine Willie’ because he gave cigarettes to the wounded and dying, won a Military Cross at Messines Ridge after running into no man’s land to help the wounded during an attack on the German front line. When TB Hardy, a fellow chaplain, asked Studdert-Kennedy how best to serve the military, he replied,

Live with the men, go everywhere they go. Make up your mind you will share all their risks and more, if you can do any good. The line is the key to the whole business. Work in the front and they will listen to you, but if you stay behind, you are wasting your time. Men will forgive you anything but lack of courage and devotion.⁷

As regards spiritual work, Studdert-Kennedy argued “there is very little, it is all muddled and mixed. Take a box of fags in your haversack, and a great deal of love in your heart and go up to them, laugh with them, joke with them. You can pray with them sometimes, but pray for them always.”⁷

Although not a front-line chaplain, PB “Tubby” Clayton achieved the respect of soldiers through his concern for their welfare. He opened a hostel for servicemen in Poperinghe, close to Ypres, which served both as a church and a club. Called Talbot House (or Toc-H, the symbol for the house in Morse code), it was located close to the red light district to offer spiritual support. Chaplains stopped soldiers going past the house on their way to brothels, not only because they considered this immoral but were aware that soldiers who caught venereal diseases would be operationally ineffective. Toc-H served as a haven where servicemen could relax alongside fellow soldiers, make confession, pray, or seek counsel.⁸

Killing was an all-too-familiar aspect of trench warfare, and the chaplain was the army’s official mediator of grief. The death of a close comrade could not only undermine morale but also trigger psychological disorder. The chaplain with empathy and the respect of his men could plausibly maintain the equilibrium of a hard-pressed battalion. For example, Sergeant Major Ernest Shephard noted amongst reports of battle in his diary: “Church parade . . . very good service . . . and a good sermon by our chaplain, Sub-Dean Barry, DSO.”⁹

During World War I, stigma was attached to both psychiatric illness and cowardice. A chaplain who visited the front line provided an opportunity for soldiers to speak about distressing thoughts or feelings without being labeled mad or “windy.” By providing an alternative source of help, he may have reduced the number of personnel taken out of action as a result of psychological illness since formal treatment in field hospitals often involved a lengthy rehabilitation process. Chaplains may not have appreciated the contribution that they were making in terms of bolstering the numbers of operationally effective personnel. Importantly, whether or not soldiers needed absolution or advice, chaplains offered soldiers an opportunity to talk through personal problems in a confidential manner.

WORLD WAR II

Traditional criticisms of chaplains were resurrected during World War II. As noncombatants, chaplains were eligible for repatriation from prisoner-of-war (POW) camps under the terms of the 1929 Geneva Convention.¹⁰ In practice, however, most remained in captivity and were held in camps for officers, leaving some stalags for NCOs and other ranks without a spiritual representative. “Most of the chaplains that we met in France, and subsequently in Germany, were completely useless and hopeless,” wrote a Royal Army Medical Corp orderly attached to various POW hospitals.¹¹ HCM Jarvis, a medical student at Lamsdorf camp, recalled that padres “were regarded as parasites” and accused them of stealing rations.¹² The 18 chaplains held at Oflag VII-C won little respect having spent most of their captivity debating denominational issues amongst themselves. In such cases, the spiritual vacuum was often filled by laymen, Toc-H members, who seized the initiative and organized communal worship. As in World War I, the impression created from letters and diaries is that a minority put exceptional effort into their ministry. The Revd David Wild, for example, requested a transfer from Oflag VI-B at Warburg to Stalag IV-B at Neubrandenburg where he was the sole priest in a camp for U.S. enlisted soldiers.¹² The Revd Bob McDowall secured a transfer to Stalag IV-B where he attracted congregations of over 600 men.

In the aftermath of World War II, Gregory (1947)¹³ advanced the unproven argument that the contribution of chaplains to the mental health of their troops was largely unconscious, by providing them with confidence by virtue of their presence. Some servicemen sought solace from trauma in formal religious services. Many military personnel felt, as some do today, that

if a man of God was with them, nothing bad could happen. Soldiers respected chaplains if they risked their own lives, for example, by going into dangerous areas to assist the wounded or minister the last rites.¹³

In the U.S. Army, a shortage of psychiatrically trained medical officers sometimes left the chaplain as the only source of help for soldiers with psychological problems. Gregory (1947)¹³ argued that chaplains may have been effective at pointing out factors that the soldier had been ignoring or overlooking in a similar fashion to more modern Rogerian, client-centered therapy. Chaplains offered nondirective and reflective discussion without aiming to interpret or advise except to encourage where they thought it necessary. The Rogerian approach assumes that an individual has the ability to deal with his or her own personal problems and the best course for the therapist is to offer a nonjudgmental, accepting atmosphere within which to explore and deal with these issues.^{14,15}

During World War II, the British Army introduced “padre’s hour” for deployed troops. This was a dedicated period of time each week when chaplains briefly addressed soldiers about a topic they considered important and then answered questions.¹⁶ However, it was found that 75% of the questions were related to socioeconomic matters with only 15% being purely religious. Some questions were said to have baffled chaplains, for example, “How can you justify the church’s ownership of slum property?”¹⁶

Historical evidence from the two world wars suggested that informal pastoral activities were more acceptable to soldiers and commanders than formal ones. Secondly, in order to be truly effective, a chaplain had to be “at one” with the men and face the same risks that they did. Lastly, the beneficial effects, in terms of health and operational efficiency, accomplished by chaplains through their provision of informal counseling may have been achieved unconsciously.

CONTEMPORARY CHAPLAINS

Within the British Armed Forces, chaplains serve all over the world; they are present in base locations, in ships, and with deployed forces operating in conflict zones such as Afghanistan. Their mental health roles include crisis counseling, marriage counseling, and bereavement counseling and general support where ever military personnel are serving. In addition, the British Army Chaplaincy Centre offers counseling courses to UK armed forces.

Military personnel encounter death not only on the battlefield but also in civilian settings such as a motor vehicle accident, suicide, or indeed death in the line of duty. The death of individuals in the armed forces affects many, including immediate family, neighbors, friends, and those that Budd (1999)¹⁷ describes as the deceased “military family.” An individual’s “military family” includes those with whom they have trained, served, lived, and deployed on operational duties.

Findings from a study completed by Bruce et al (1990)¹⁸ suggest that suffering bereavement greatly increases the risk

of depression that may require clinical intervention. A chaplain may be the sole provider of counseling for the bereaved, and if a significant problem is acknowledged by the chaplain, referral is needed. Milstein et al (2008)¹⁹ argue that a chaplain as someone who regularly comforts grieving families could be the first to recognize signs of clinical depression. Chaplains need to refer the bereaved to mental health care providers if they feel it is necessary; this is to determine whether the individual has a major depressive disorder or has other clinical needs—such as medication. In a survey of Christian clergy and in a national survey of Imams and Rabbis, Milstein et al (2008)¹⁹ identified that clergymen recognize the difference between bereavement and depression but are unsure of how to collaborate with clinicians.

Budd (1999)¹⁷ suggests that most service personnel who seek advice from U.S. military chaplains present with relationship problems. One chaplain reported to Budd that that 60% to 80% of his and his colleagues’ time was spent providing marital counseling. It is likely that the same situation applies to UK Armed Forces where it has been shown that the effects of an unhappy home life considerably affect the ability of personnel to work efficiently. A number of studies have shown that divorce and separation can contribute significantly toward depression, anxiety, and an increased chance of alcohol abuse.^{20,21} Support from a chaplain may help resolve problems within a marriage by providing a confidential, informal, and experienced confidant.

Military chaplains, unlike doctors, are the only people that service personnel can talk to in complete confidence. Budd (1999)¹⁷ argues that in the collaboration between military psychiatrists and chaplains, the key selling point for using chaplains versus a psychiatrist is the confidentiality. Military psychiatrists and health care professionals are often seen by personnel as spies for the employer. Psychiatrists are required to report specific subjects to higher authorities such as spousal abuse, child abuse, alcohol misuse, and intent to harm others.

The available literature, although sparse, appears to suggest that a chaplain’s “Ministry of Presence” has raised the morale of soldiers on the battlefield. High morale has long been known to have a positive psychological effect on soldiers. In World War I, low morale was thought to be a contributing factor to shell shock. Jones and Wessely (2005)²² report that after the Southborough inquiry²³, it became doctrine that properly trained troops that were well led with high morale were virtually immune from psychological breakdown. High levels of morale have been shown to enhance performance both while deployed on and following recovery from operations. In a study of troops deployed on peacekeeping operations, morale was strongly related to the perception that they were participating in meaningful work, and those with high levels of morale had confidence in unit functioning and leadership.²⁴

Within the United Kingdom, chaplains engage in structured schemes designed to support armed forces personnel, including trauma risk management (TRiM) and decompression

programs. TRiM, a model that began with the Royal Marines Commandos and now practiced across all three services, provides support, advice, and education to keep an individual functioning after a traumatic event.²⁵ TRiM practitioners are nonmedical personnel that have been trained to give psychological first aid. In addition, TRiM practitioners seek to identify those who may not be coping and need further referral. Some chaplains trained in TRiM methods act as support to other TRiM practitioners.

Decompression is a process whereby service personnel are provided with an opportunity to adjust from the high tempo of operational duties (for UK troops, this usually takes place in Camp Bloodhound, Cyprus). During this time of shared experiences immediately after deployment, mental health care professionals are at hand if needed.^{26,27} At least one chaplain is present during decompression. They offer homecoming briefings (covering the reestablishment of relationships with family and friends) and a “ministry of presence” providing informal supportive counseling.

TRiM and decompression are preventative measures put in place for UK troops to help personnel cope with operational experiences. A recent UK study reported probable PTSD rates of 4% and symptoms of common mental health disorders of 19.7%.²⁸ Another study completed during a deployment to Afghanistan found a prevalence of probable PTSD of 2.9%, while 17.3% of the deployed personnel had symptoms of common mental health disorders.²⁹ Although these figures indicated generally good mental health for UK armed forces, the intensity of operations in Afghanistan may have been offset to some degree by the continued use of preventative measures such as TRiM and decompression. Chaplains contribute to these processes, and their role should not be overlooked. Their skills can be utilized when personnel are unwilling to seek help for mental health problems through the usual avenues—such as seeing a medical officer, particularly when they are in dangerous situations. Individuals may actively avoid seeking care because of the stigmas related to mental health,^{30,31} and helping to overcome stigma is another potential benefit of close collaboration between a chaplain and a clinician. Although it is not possible to draw any firm conclusions on the UK armed forces data on suicide³², it is possible that personnel who are considering suicide might consider the use of a chaplain as a far more acceptable avenue of “last resort” than a medical center or other less confidential source of potential support.

CHAPLAIN CLINICIAN COLLABORATIVE MODEL

Research has consistently indicated that a successful relationship between chaplains and clinicians requires them to enter a collaborative relationship with the aim of identifying and treating mental health problems.^{19,33–37} Military chaplains, working alongside mental health professionals, can provide a range of services including the use of supportive counseling, which be provided in a more confidential manner than mental health of personnel would be able to do.

Collaborative care requires a chaplain to assess whether a member of the armed forces in distress can be best helped by them providing advice or counseling or whether a consultation with a mental health clinician is required. Although some personnel might not initially want to consider the use of mental health services, hence them asking a chaplain for help in the first instance, a collaborative chaplain would use the first few sessions with the individual, who they deem to need mental health care, to shift this view. As the patient’s view shifts, the chaplain can then explain that accessing mental health care appears to be the best course of action. The chaplain may pass on any relevant information to the mental health team if they can obtain the patient’s consent. If the patient is referred to a clinician, he or she may continue to see the chaplain as well; where both chaplain and mental health professional continue to see the same individual for support and/or care, it is helpful for them to regularly swap relevant information within the limits of confidentiality.

However, it is worth noting that a chaplain’s ability to help distressed personnel has some limitations, particularly where distressed individuals may pose a risk to themselves or others. Ideally, close liaison between chaplain and medical professionals will allow the health care professional’s experience in risk management to work alongside the chaplain’s ability to provide confidential support and to discuss nonclinical but potentially important theological matters.

Thus collaboration between chaplains and mental health professional should serve to enhance the skill sets of both professionals. Mental health professionals should be able to provide a comprehensive range of evidence-based treatments, which the majority of chaplains would not be able to, while chaplains can offer an avenue of support that can be far more confidential than a mental health professional could provide. Effective collaboration may well improve the ability of both professional groups to successfully return service personnel to a good state of health. More detailed scrutiny of the collaborative process could be the subject of scientific evaluation.

CONCLUSIONS

We conclude that with the correct training and a sufficiently mutual understanding of each other’s roles, a collaborative model between military doctors and chaplains is likely to prove successful in improving the mental health of service personnel. Successful joint working relies upon chaplains maintaining and updating their counseling skills and improving their understanding of emergent mental health issues. Also, while religion is an understandably important part of chaplains’ military roles, care needs to be taken not to confuse the religious role with the mental health one. Lastly, we also suggest that a formal collaborative model should be clear as to when chaplains should refer cases on to, or at least liaise closely with, mental health professionals to ensure the best possible outcome for distressed service personnel.

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